your health
NETWORK
A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS
July 2006 Volume 14, Number 1

inside

Annual Transfer Period to be Held in the Fall

October 16 through November 15 is the time frame for this year's annual enrollment transfer period. You will have the opportunity to change health, dental (if available) and life (state plan only) insurance coverages during this time. Changes will be effective January 2007.

The state group insurance program does not have an open enrollment period for health coverage. Annual transfer only provides the opportunity to change your healthcare option for you and your covered dependents. For information on late applicant procedures for individuals who do not elect health coverage during their initial eligibility period, please refer to your insurance handbook.

To select the best healthcare option for you and your family members, it's a good idea to familiarize yourself with the structure of the available options.

PPO

A health insurance option where participants choose a network provider or a non-network provider. While PPO participants may use any physician, you will receive full benefits by using a network provider. A network provider accepts a pre-negotiated fee and the participant is responsible for a percentage of the maximum allowable charge and an annual deductible. When a patient utilizes a non-network provider, care is paid at a lesser percentage of the maximum allowable charge and charges above the maximum allowable are the patient's responsibility (these charges can be significant). Annual out-of-pocket maximums apply.

POS

A health insurance option where participants use in-network providers who have agreed to accept a fixed copayment. Use of out-of-network providers is covered at a percentage of the maximum allowable charge and charges above the maximum allowable amount are the patient's responsibility. There are no deductibles to meet as long as you use in-network providers. There is no out-of-pocket maximum under this option. Participants are not required to designate a primary care physician and referrals are not required when utilizing in-network providers.

HMO

A health insurance option where all care is coordinated through a primary care physician. No benefits, other than approved emergency or urgent care, are paid outside of the HMO's network. Copayments are paid each time services are received and there are no deductibles to meet. There is no out-of-pocket maximum and pre-existing condition exclusions do not apply.

Medicare Part D Pharmacy Plan and Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the state-sponsored healthcare options (PPO, POS and HMO) and prescription drug coverage available for people eligible for Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. This notice applies to you and your covered family members who are eligible for Medicare. **If you are actively employed, you do not need to enroll in Medicare prescription drug coverage.**

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare advantage plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The insurance committees have determined that the prescription drug coverage offered under the state-sponsored healthcare options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing state-sponsored coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiary's leaving state-sponsored coverage may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your state-sponsored coverage, which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the state-sponsored healthcare options and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the state-sponsored options changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.Medicare.gov
- Call your state health insurance assistance program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

notable

During the year 2005, plans sponsored by the state paid $6.9 million for the brand named prescription drug Zocor and $3.1 million for the brand named drug Zoloft. Zocor is prescribed for patients with high cholesterol levels and Zoloft is used to treat depression. It is anticipated that both these drugs will come off patent by the fall of this year. This means that lower cost generic equivalent drugs will become available. We will be working with our claims administrators in developing a plan to notify affected plan members when those generic drugs become available.

The financial section of the Division of Insurance Administration's website has been updated with 2005 data. We encourage you to review this information if you would like a better understanding of plan benefits, utilization and the continuing increase in healthcare costs.

Please be advised that for services to be covered under your health insurance, they must be medically necessary. Having a physical for the purposes of playing a sports event or attending camp are not covered expenses.

Always use participating network providers to receive maximum benefits. Participating network providers have agreed to accept the maximum allowable charge amount and write off the rest of the charge after applicable deductible, coinsurance and copay amounts are paid by the member.

To order additional or replacement insurance ID cards, please call the claims administrator for your healthcare option. Each insurance company also offers the ability to order cards online via the internet. For a complete list of website links, please visit the Division of Insurance Administration's website at www.state.tn.us/finance/ins/

Retirement Planning

If you are planning to retire, it is very important that your application to continue insurance coverage and your application for retirement, if applicable, be submitted 60 to 90 days prior to your last paid day of service. You should refer to your insurance handbook for eligibility requirements for continuation of insurance.

If you are under 65, you should complete the *Application for Continuation of Insurance Coverage at Retirement*. If you are 65 or older at the date of your retirement and wish to continue insurance, you may enroll in the Tennessee Plan, the Medicare supplement policy offered by the state.

Enrollment forms may be obtained from your agency insurance preparer or you may obtain a copy on the internet.

Tennessee Consolidated Retirement System (TCRS) participants should visit www.treasury.state.tn.us/tcrs/ or call 1.877.681.0155. Your application to continue insurance coverage should accompany your application for retirement.

Those enrolled in an optional retirement plan should visit www.state.tn.us/finance/ins/ or call 1.800.253.9981 for the appropriate forms to apply for continuation of insurance coverage.

Out-of-Country Benefits

The state group insurance program provides benefits for out-of-country care subject to the following terms and conditions. Questions regarding coverage for specific services or the availability of providers participating in an out-of-country network should be directed to the claims administrators — BlueCross BlueShield, CIGNA or John Deere Health.

- Benefits are only available if a covered person is traveling out of the country on business or pleasure when the need for medical care occurs. The covered person may be required to provide documentation to the claims administrator detailing the nature of the travel.
- No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the U.S., even if the medical service is a covered benefit within the U.S.
- All services must be medically necessary as determined by the claims administrator.
- In an emergency situation (as determined by the claims administrator), network-level benefits are available to covered persons enrolled in the PPO, PPO-Limited, POS or HMO, regardless of whether or not the providers are participating in an out-of-country network.
- For urgent care and routine care situations under the PPO, PPO-Limited and POS, network-level benefits are available through participating providers. If there is no out-of-country network or the covered person goes to a provider who is not participating in an out-of-country network, the lower level (out-of-network) benefits will apply, and the cost to the member could be substantial.
- Covered persons enrolled in the HMO option have no coverage for routine care services received out-of-network (outside the U.S.). Urgent care situations require PCP referral or advance approval by the claims administrator or there is no benefit.

Mental Health and Substance Abuse Benefits

No matter which healthcare option you have selected, you have convenient and confidential access to mental health and substance abuse benefits.

The contracted provider for all plan members is Magellan Health Services. Your specific benefit-covered mental health and substance abuse services depend on your particular healthcare option (see grid below), but services generally include:

- Outpatient assessment and treatment
- Individual and group treatment
- Inpatient assessment and treatment
- Alternative care such as partial hospitalization and intensive outpatient treatment
- Treatment follow-up and aftercare

To receive the maximum benefit coverage for your care, you must use a network provider and obtain preauthorization of your care. You can call Magellan toll-free at 1.800.308.4934 any time, day or night, to speak confidentially with a trained professional for a referral.

Under the PPO option, you may see a mental health provider without calling, however, your coinsurance and copayments will be higher if you do not receive preauthorization. You may also be at risk of having inpatient benefits totally denied. Under the POS and HMO options, both outpatient and inpatient services must be preauthorized to a network provider prior to the delivery of the service or benefits will be denied.

All intermediate levels of care will be counted as inpatient for the purposes of plan limitations. The following guidelines apply:

- Residential treatment is defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. (1.5 residential treatment days = 1 inpatient day)
- Partial hospitalization is defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least four hours per day and are available at least three days per week, although some patients may need to attend less often. (2 partial hospitalization days = 1 inpatient day)
- Intensive outpatient is defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least two hours per day and three days per week, although some patients may need to attend less often. (5 structured outpatient days = 1 inpatient day)

Please call Magellan Health Services for more information regarding your mental health and substance abuse benefits or visit their website at www.magellanhealth.com

	PPO		POS	HMO
	In-Network	Out-of-Network	In-Network Benefit Only	In-Network Benefit Only
Mental Health Inpatient	90% of MAC; Limited to 45 days per year	70% of MAC; Limited to 45 days per year	$100 copay per admission; Limited to 30 days per year	$100 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient	90% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	70% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health and Substance Abuse Outpatient	Sessions 1-15: $5 copay per session Sessions 16-45: $25 copay per session Limited to 45 sessions per year mental health and substance abuse combined	Sessions 1-15: $40 copay per session Sessions 16-45: $100 copay per session Limited to 45 sessions per year mental health and substance abuse combined	$25 copay per session; Limited to 45 sessions per year mental health and substance abuse combined	$20 copay per session; Limited to 45 sessions per year mental health and substance abuse combined
Deductible	$150 per individual (separate from medical deductible)		None	None

MAC = maximum allowable charge
If PPO members use non-network providers, they will be responsible for payment of charges above the MAC.
For the purpose of substance abuse lifetime maximum limitations, a stay is any substance treatment counted as inpatient where the duration is between 1 and 28 inpatient days or 1 and 5 inpatient days for detox. For example, an inpatient stay of 3 days for detox equals one lifetime 5-day detox stay.

CIGNA Guest Privileges Program for POS Participants

The CIGNA HealthCare guest privileges program provides healthcare coverage when you are away from home for an extended period. Whether your job takes you to a new city for a few months, or one of your participating family members is away at school.

When away for a temporary period of more than 60 days, but no more than two years, you or your participating family member can inquire with a CIGNA HealthCare customer service representative to see if your are eligible for the guest privileges program. If CIGNA HealthCare has a POS network in the area you are temporarily located and your medical plan design meets that specific states legislation and mandates then you will be eligible to participate. You will not just be covered for emergency care, but for all of your routine and preventive care benefits as well.

To inquire about guest privileges, call CIGNA toll-free at 1.800.244.6224. A customer service representative will discuss your situation and confirm your eligibility for the program. If you are eligible, the representative will take your information and enroll you in the guest privileges program. Further information will then be mailed to your home address.

When You're Ready To Come Home

Call CIGNA HealthCare's customer service number at least one week before you leave your temporary residence. A customer service representative will make sure your coverage will be changed back to your original home location as it was before you left.

Please Remember

To ensure smooth transition of coverage to your guest location or back to your home area when you return, be sure to call customer services at least one week before your move. ***Failure to call may result in benefits being denied.***

The benefit plan available at your guest location will be the same as your home benefit plan. However, in some situations, state mandates may mean a difference in benefits. Call customer services for assistance with any benefits questions.

Children living away from home may participate in the program as long as they continue to meet dependent and/or student eligibility status requirements.

For more information about the guest privileges program — or anytime you have a question about your coverage or benefits — call customer service at the toll-free number listed on the back of your ID card.

State Issues Requests for Proposals

All services offered by the state group insurance program are procured through a competitive process, usually a request for proposals. Contracts are then awarded to the best evaluated proposer based on a specified set of criteria.

The contract for claims administration of the PPO and PPO Limited (available to local government plan members only), which is currently held by BlueCross BlueShield of Tennessee, will expire December 31, 2006. The division is currently conducting a procurement for the provision of these services effective January 1, 2007. Should the outcome of this procurement result in a change of insurance companies, this will be communicated to all plan members during the annual transfer period, which will be held from October 16 through November 15, 2006.

Play an Active Part in Life

We all know that a poor diet and inactive lifestyle can lead to serious health problems and also make some diseases more difficult to treat. But did you know that being overweight affects healthcare costs?

Unhealthy lifestyle choices are a big reason healthcare costs are going up. In fact, if you add up the cost of health problems caused by being overweight, the nationwide total is almost $120 billion in avoidable healthcare expenses each year. Those costs affect what you pay for your health coverage, as well.

Each of us has the ability to help control healthcare costs by establishing an exercise plan that meets our individual needs. For example, brisk walking for 30 minutes a day, three times a week, can not only improve personal health but can also reduce your need for medical services.

Take steps to keep a healthy weight or lose weight. Plan to bypass heart disease and other serious health problems whenever possible. Talk to your doctor about an exercise plan that works for you.

When it comes to the cost of healthcare, you have a choice. And your choices make a difference.

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